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No. ——

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

AETNA LIFE INSURANCE COMPANY, a Connecticut corporation, doing business in Florida, and SOUTHERN BELL TELEPHONE & TELEGRAPH COMPANY,

Petitioners,

v.

KENNETH KANE, individually and as Guardian, next friend and on behalf of JONATHAN ANDREW KANE, a minor,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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QUESTION PRESENTED

Whether common law estoppel may be used to enforce an oral representation as to coverage under an "ERISA" plan where the representation modifies the terms of the written plan.

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Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Aetna Life Insurance Company and Southern Bell Telephone & Telegraph Company petition for a writ of certiorari to review the decision of the United States Court of Appeals for the Eleventh Circuit, in this case.[1]

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[1] There are no additional parties in this proceeding. The parent corporation of Southern Bell Telephone and Telegraph Company is BellSouth Corporation. Its sole subsidiary is BellSouth Services, Inc. The parent corporation of Aetna Life Insurance is Aetna Life and Casualty Company. Aetna's subsidiaries are American Health Capital HIBI Management, American Health Capital Insurance Company, Ltd., Dayton Arcade Community Redevelopment Corporation, Med Southwest, Inc., and VHA Enterprises, Inc.

OPINIONS BELOW

The opinion of the court of appeals (App. A) is reported at 893 F.2d 1283 (11th Cir. 1990). The opinion of the trial court (App. B) is not reported.

JURISDICTION

The Eleventh Circuit entered its decision on February 7, 1990, at which time the judgment of that court was entered. (App. A) Petitioners timely served their suggestion for rehearing en banc on February 26, 1990, (App. C) which the court denied on April 6, 1990. (App. D) The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1), which permits review of decisions that conflict with decisions of other circuit courts and with this Court on the same matter, and § 2101(c). *See* Rules of the Supreme Court 10.1(a) and (c).

STATUTORY PROVISIONS INVOLVED

Pertinent parts of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C.S. § 1001, *et seq.* (1990), appear below:

> 1. § 1001. **Congressional findings and declaration of policy**
>
> **(a) Benefit plans as affecting interstate commerce and the Federal taxing power.** The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate

character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained: that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries. It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and

other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance. It is hereby further declared to be the policy of this Act to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

(Sept. 2, 1974, P.L. 93-406, Title I, Subtitle A, § 2, 88 Stat. 832.)

2. § 1003. Coverage

(a) Except as provided in subsection (b) and in sections 201, 301, and 401 [29 USCS §§ 1051, 1081, and 1101 (1990)], this title shall apply to any employee benefit plan if it is established or maintained—

(1) by any employer engaged in commerce or in any industry or actively affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or any industry or activity affecting commerce; or

(3) by both.

(b) The provisions of this title shall not apply to any employee benefit plan if—

(1) such plan is a governmental plan (as defined in section 3(32) [29 USCS § 1002(32) (1990)]);

(2) such plan is a church plan (as defined in section 3(33) [29 USCS § 1022(33) (1990)]) with respect to which no election has been made under section 410(d) of the Internal Revenue Code of 1986 [26 USCS § 410(d) (1990)];

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 3(36) [29 USCS § 1002(36) (1990)]) and is unfunded.

(Sept. 2, 1974, P.L. 93-406, Title I, Subtitle A, § 4, 88 Stat. 839; Dec. 19, 1989, P.L. 101-239, Title VII, Subtitle G, Part V, Subpart D, § 7891(a)(1), 103 Stat. 2445.)

3. § 1002. **Establishment of plan**

(a) Named fiduciaries.

(1) Every employee plan shall be established and maintained pursuant to a written instrument. . . .

* * * *

(b) Requisite features of plan.

Every employee benefit plan shall—

* * * *

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan . . . ,

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

4. § 1132. **Civil enforcement**

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109 (1990)];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of violation of 105(c) [29 USCS § 1025(c) (1990)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1).

5. § 1144. **Other laws**

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede

any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a) (1990)] and not exempt under section 4(b) [29 USCS § 1003(b) (1990)]. This section shall take effect on January 1, 1975.

STATEMENT OF THE CASE

This case arises out of an alleged oral modification of an ERISA plan. The Eleventh Circuit has now decided that common law estoppel can be plead to find coverage based upon an oral representation as to coverage where the representation modifies the terms of the written plan. This ruling, if left to stand, offends the express Congressional intent, as well as decisions of this Court and other circuits, providing exclusive remedies under the civil enforcement provisions of ERISA.

Kenneth Kane, individually and as Guardian, next friend and on behalf of Jonathan Andrew Kane, ("Kane") sued Aetna Life Insurance Company ("Aetna") and Southern Bell Telephone & Telegraph Company ("Southern Bell") for damages for refusal to pay ERISA benefits. Aetna and Southern Bell moved for summary judgment claiming that Kane is not entitled to recover because coverage under ERISA plans cannot be expanded by oral representations. The District Court agreed and granted a final summary judgment. (App. B) The Eleventh Circuit reversed. 893 F.2d 1283.[2]

Jonathan Kane was born prematurely on May 19, 1984. Two weeks after his birth, the Kanes learned about Jonathan for the first time and further learned that he was available for adoption. Before they com-

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[2] The fact statement is presented in a light most favorable to Kane because the case is presented in a summary judgment posture. Aetna and Southern Bell do not admit that certain allegations taken as true for summary judgment purposes could be established at a trial on the merits.

mitted to adoption, however, the Kanes wanted assurance that the child's full hospital stay was covered under Mr. Kane's ERISA medical plan, which was self-funded by his employer, Southern Bell, and administered by Aetna. The child was hospitalized from his birth until July 5, 1984.

The ERISA plan in issue states that a continued hospital confinement which commences prior to the effective date of plan coverage, and charges for services received before dependents are covered, are excluded from coverage. The plan further states that a covered child includes *legally adopted children*, including "those who are in the formal legal process of adoption, regardless of residence." (App. E) The plan expressly excludes, however, coverage for charges incurred during a continuous hospital confinement *which commenced prior to the effective date of the individual coverage.*

On May 29, 1984, Mrs. Kane called a "toll free" number contained in the plan summary to ask about coverage. An Aetna employee apparently told her that any adopted child would be covered. Approximately two weeks later, a hospital employee called Aetna and was ostensibly told that the child would be covered. Relying on the oral representation, the Kanes decided to adopt Jonathan.

Despite Kane's claim of an enforceable oral modification, Aetna refused coverage because the plan expressly excludes coverage of charges incurred during a continuous hospital confinement which commenced prior to the effective date of coverage for an individual. Since coverage for an adopted child is excluded until formal adoption proceedings are commenced, the continuous hospital confinement commencing prior to adoption proceedings was excluded. The Eleventh Circuit nevertheless found that common law estoppel could be asserted to enforce an oral modification of an ERISA plan, and reversed. 893 F.2d at 1285-86.

BASIS FOR FEDERAL JURISDICTION

The basis for federal jurisdiction in the court of first instance is 28 U.S.C. § 1332, in that a federal question was raised relating to the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C.S. § 1001, *et seq.* (1990).

REASONS RELIED ON FOR ALLOWANCE OF THE WRIT

This case presents an important question, the resolution of which is necessary to preserve the integrity of the express preemption provisions of ERISA, which are designed to establish ERISA regulation as an exclusive federal concern. The case involves the refusal of a United States Court of Appeals—despite controlling legal principles, the express wording of the ERISA plan in issue, and the Congressional emphasis on the breadth and importance of federal preemption—to recognize that a common law cause of action based upon estoppel cannot be asserted to force a plan administrator to pay benefits on the basis of an informal exchange over a telephone regarding the extent of plan benefits. This case presents an example of what occurs when a court ignores a rule of strict construction in order to find coverage under apparently compelling facts, and in the process creates bad law. The importance of granting certiorari is underscored by the fact that ERISA claims are proliferating, and parties who pursue such claims must be limited exclusively by the comprehensive category of remedies provided by Congress. Failure to limit claims to the express written provisions of a given plan will result in variable benefits for participants of the same plan, thereby threatening the stability, financial soundness, and equitable character of such plans. It is submitted that when the facts of this case are reviewed in the context of the controlling law, the importance of granting the petition will be evident.

I. FEDERAL CIVIL REMEDIES ARE EXCLUSIVE UNDER ERISA

The Eleventh Circuit's decision holds that a beneficiary may be entitled to rely on oral representations where elements of common law estoppel are present. This decision directly conflicts with this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39 (1987), holding that the statutory civil enforcement provisions under ERISA are exclusive. The sole issue in *Pilot Life* was whether ERISA preempts state common law actions asserting improper processing of a claim for benefits under an employee benefit plan. The Court held that all such claims were indeed preempted.

In its opinion, the Court notes these specifics about ERISA. First, ERISA comprehensively regulates employee welfare benefit plans. *Id.* at 46. The express provisions of ERISA are deliberately expansive, and are designed so that plan regulation is solely a federal concern. *Id.* Second, Congress clearly expressed an intent that the civil enforcement provisions of ERISA, Section 502(a) (29 U.S.C.S. § 1132(a) (1990)), are the exclusive vehicle for actions by ERISA plan participants and beneficiaries. *Id.* at 50-51. In this regard, the Court stated:

> The conclusion that section 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of section 502(a) was modeled on the exclusive remedy provided by section 301 of the Labor-Management Relations Act.

Id. at 51. The Court then went on to state the following regarding the manner in which plan benefits must be determined:

> Under the civil enforcement provisions of section 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify

> rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty . . .
>
> . . . . [T]he detailed provisions of section 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in section 502(a) of the statute as finally enacted . . . provided strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." [citing *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 87 L.Ed.2d 96 (1985).]
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> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that *ERISA's civil enforcement remedies were intended to be exclusive.* This conclusion is fully confirmed by the legislative history of the civil enforcement provision.

Id. at 51-52 (emphasis added). By its ruling that Kane may assert a cause of action based upon estoppel, the Eleventh Circuit's decision expressly conflicts with *Pilot Life.*

It is true that federal common law may be applied to govern federally preempted areas, but only where the federal statute does not expressly address the issue before the court. *See Holland v. Burlington Indus., Inc.*,

772 F.2d 1140 (4th Cir. 1985), *cert. denied*, 477 U.S. 903 (1986). In this case, the very wording of the statute makes its intent clear. This situation involves nonpayment of benefits under a self-funded ERISA plan. Thus, the *only* remedies available are the statutory remedies to determine entitlement to benefits under the plan *as written*. If common law estoppel were permitted as a viable theory, then, as noted in *Pilot Life*, the strict policy of federal preemption reflected in the all-inclusive choice of civil remedies under the statute would be undermined.

II. BY PERMITTING A CLAIM TO BE ASSERTED UNDER AN ESTOPPEL THEORY, ERISA BENEFITS UNDER THE SAME PLAN COULD VARY

This case may evoke sympathy for the adoptive parents who say that they would not have adopted Jonathan had there been no coverage. However, the Kanes are subject to the same standards under federal law as any other claimant seeking ERISA benefits regardless of the circumstances. Nevertheless, it appears as though the Eleventh Circuit felt compelled to find some theory for recovery, and in the process not only ignored *Pilot Life* and decisions from the Ninth and Tenth Circuits, but also ignored its own prior ruling in *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986).

The question in *Nachwalter* was whether the federal common law of estoppel could be used to enforce an oral modification of an ERISA plan. The trial court entered summary judgment in favor of the plan administrators, holding that neither oral agreement nor "informal exchange" may be used to modify the written terms of the plan. *Nachwalter v. Christie*, 611 F. Supp. 655 (S.D. Fla. 1985). The Eleventh Circuit affirmed that ruling. It recognized that *any* oral representation as to plan coverage cannot be binding because to do otherwise would undermine the purpose of ERISA in requiring an

administrator (a) to determine who is to receive benefits on a uniform basis, and (b) to pay benefits pursuant to the written instrument of the plan.

By applying common law estoppel (which is always adopted from the law of the state in which the federal court sits), the uniformity of administration is undermined because rights under the plan would, among other things, depend upon an interpretation of state law. Thus, a large company such as Southern Bell, which has plan participants in many states, could not rely on section 502 in determining its plan liabilities. These companies would have to consider the additional variable of common law depending on each plan participant's home state. This is precisely what Congress was attempting to avoid when it declared that ERISA—without exception—would preempt state law.

The Eleventh Circuit nevertheless has attempted to distinguish *Nachwalter* by finding that in this case the administrator was interpreting an ambiguous provision of the plan, rather than modifying the plan. First, the proper remedy would have been a declaratory judgment action allowed by the statute regarding the extent of coverage. The "estoppel" theory and "oral modification" issue should never have entered into the equation. Second, in determining that the plan was ambiguous, the Eleventh Circuit improperly looked first to the surrounding circumstances to find that an ambiguity existed despite the trial court's finding that the plan was clear and unambiguous, and despite the fact that it was completely ignoring the statutory "choice of remedies."

What obviously happened here is that the court wanted to find coverage and did just that simply by declaring the plan to be ambiguous. The opinion makes this obvious. For example, the plan provides that employees *and their dependents* are not covered for continuous hospitalizations beginning prior to the effective date of coverage. It also provides that dependent coverage becomes

effective on the date eligibility requirements are met provided dependents have been enrolled. It is clear that the infant was not enrolled because the Kanes had decided that enrollment would be a condition precedent to adoption. The court's interpretation nonetheless allows Kane to adopt a child and render the plan responsible for benefits without regard to the strict construction ERISA requires. Plan participants can now pursue enforcement remedies—including estoppel—beyond the statutory limitation on civil remedies.

Ironically, *Nachwalter* itself has been interpreted to reject outright the applicability of common law estoppel. For example, in *Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988), the Tenth Circuit stated:

> Following the lead of the Eleventh Circuit, we hold that no liability exists under ERISA for purported oral modifications of the terms of an employee benefit plan. [Citation to *Nachwalter.*] As the court noted in *Nachwalter*, under ERISA *all* "employee benefit plans [must] 'be established and maintained pursuant to a written instrument.'" *Id.* at 960 (quoting 29 U.S.C. § 1102(a)(1)). . . .
>
> * * * *
>
> The *Nachwalter* court also rejected an attempt to apply federal common law so as to allow oral modifications of employee benefit plans.

Id. at 1265 (emphasis added). Despite *Nachwalter*, the current ruling now creates conflict not only with the Tenth Circuit in *Straub*, but also with the Fifth and Ninth Circuits. In a case virtually identical to this one, the Ninth Circuit held that a beneficiary could not assert an estoppel claim. In *Hansen v. Western Greyhound Retirement Plan*, 859 F.2d 779 (9th Cir. 1988), Hansen became disabled at the age of fifty-two. He applied for and received disability retirement benefits under the only plan for which he qualified because of his age. When he reached age fifty-five, he applied for another plan. The administrator denied the application on the ground that

he did not qualify to change plans. Hansen brought an action claiming that the administrator was estopped from denying the application because he chose disability retirement benefits at age fifty-two on the advice of the Retirement Plan Administrator, who did not tell him he could not later switch. The court denied the claim outright, stating:

> It is the law of this circuit, recently reaffirmed, that an employee benefit fund may not be required by estoppel to make payments not authorized by a written plan. *Davidian v. Southern California Meat Cutters Fund*, 859 F.2d 134, 135 (9th Cir. 1988).

Id. at 781. Like this case—where Kane is attempting to modify a plan only as it pertains to him—Hansen was attempting to change only the benefits he was to receive. If this were allowed, the provisions of the very same plan could not only vary from state to state, but also from participant to participant. Also like this case, Hansen was attempting to establish estoppel where a plan employee furnishes misinformation. The court rejected the argument, finding that estoppel simply does not apply to employee plans governed by ERISA.[3] *See also*, *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d

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[3] A recent case out of the Central District of California has applied the rule in a nearly identical fact situation. In *St. Mary Medical Center v. Cristiano*, 724 F. Supp. 732 (C.D. Cal. 1989), the issue was whether a newborn child was covered under her mother's health plan. The mother was told that all she needed to do to obtain coverage was to enroll the child within thirty-one days of her birth, which she did. However, the child was born prematurely and incurred enormous hospital bills. Coverage was denied on the ground that the premature birth created an unacceptable risk.

The dispute centered around interpretation of the allegedly ambiguous plan. Plaintiffs claimed detrimental reliance on the oral misrepresentations. The court found that no cause of action based on estoppel for misrepresentations of the plan administrators and fiduciaries exists. "Common law principles of estoppel are not applicable to ERISA claims." *Id.* at 743. Thus, summary judgment was granted in favor of defendants.

922, 928 (9th Cir. 1986) ("[a]n employee benefit fund . . . cannot be required on the grounds of equitable estoppel to pay benefits to a person ineligible under the plan's provisions"); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488 (2d Cir. 1988) (oral modifications cannot be enforced absent intentional fraud or bad faith).

Hansen cites *Davidian v. Southern Cal. Meat Cutters Union & Food Employees Benefit Fund*, 859 F.2d 134 (9th Cir. 1988), as authority. Davidian was about to retire when he met with a fund employee to choose retirement benefits. The employee misdescribed the benefits under the plan which Davidian chose. When his claim for benefits was denied, he sued the fund alleging that had he known the true benefits, he never would have picked that plan. Davidian brought causes of action for bad faith, fraud, deceit, breach of fiduciary duties and estoppel. The district court held that ERISA forbids recovery against a fund based on estoppel. The Ninth Circuit affirmed. Relying on its earlier decisions in *Thurber v. Western Conference of Teamsters Pension Plan*, 542 F.2d 1106 (9th Cir. 1976), and *Aitken v. IP & GCU-Employer Retirement Fund*, 604 F.2d 1261 (9th Cir. 1979), the court stated:

> ERISA did not change the law. ERISA, like the LMRA, requires that benefit plans "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1) In *Moore v. Provident Life & Acc. Ins. Co.*, 786 F.2d 922, 928 (9th Cir. 1986), decided after ERISA, we applied a no-estoppel rule in a suit for employees benefits against a jointly-sponsored trust fund. There are no contrary holdings in this circuit.

859 F.2d at 136. The court found that an estoppel action will not lie against a fund. *Id.*

Like the Ninth and Tenth Circuits, the Fifth Circuit has rejected attempts to invoke estoppel to provide a remedy under an ERISA plan. In *Degan v. Ford Motor*

Co., 869 F.2d 889 (5th Cir. 1989), Degan claimed that based on the misrepresentations of Ford employees, he chose a benefit plan that he believed provided him with partial benefits at age fifty-five and then full benefits upon attaining age sixty. When he requested a benefit application form prior to his fifty-fifth birthday, Ford responded that Degan was ineligible for the partial benefits.

The district court granted summary judgment in favor of Ford, and the Fifth Circuit affirmed on other grounds. Noting that "ERISA'S preemptive reach should be construed narrowly," the court rejected Degan's argument that he was entitled to rely on oral assurances. *Id.* at 893. The court reasoned:

> Degan presents us with a sympathetic, estoppel-based argument for fashioning federal common law that would prevent employers and union officials from consoling displaced employees like Degan with empty oral assurances about rights to pension benefits, especially when repudiation comes after years of expectations. The problem, however, is one for Congress and not this court to resolve, for we are bound by ERISA's emphatic preference for written agreements.
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> * * * *
>
> Hence, we join the other circuits that have held, consistently with the words of the statute, that ERISA precludes oral modifications to benefit plans and that claims of promissory estoppel are not cognizable in suits seeking to enforce rights to pension benefits.

Id. at 895 (citations omitted).

The logic of the court in *Degan* is clear. Until Congress chooses to broaden the range of available remedies, estoppel will not lie to create benefits where none would otherwise exist. *See also Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1297 (5th Cir. 1989) ("[W]e hold that an oral agreement cannot be the basis of a cause of action under ERISA.")

This Court has clearly stated that Congress' intent in passing ERISA and preempting the field is to be vigorously protected. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 77 L.Ed.2d 490 (1983); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39 (1987). The Eleventh Circuit has nevertheless receded from that mandate. If "estoppel" is now permitted as a basis for obtaining ERISA benefits, the deliberate care which Congress took to avoid inconsistent results will be clearly frustrated.

CONCLUSION

Allowing estoppel claims based on oral representations circumvents the ERISA requirement of written documents which assure the stability and consistency of ERISA plans. Petitioners urge this Court to grant the petition for writ of certiorari in order to address this timely issue on a uniform basis.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT

No. 88-6148

KENNETH KANE, individually and as Guardian, next friend and on behalf of JONATHON ANDREW KANE, a minor,

Plaintiff-Appellant,

v.

AETNA LIFE INSURANCE and SOUTHERN BELL TELEPHONE & TELEGRAPH,

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Florida

Feb. 7, 1990

Before VANCE * and COX, Circuit Judges, and EDENFIELD **, District Judge.

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* This opinion was written by Honorable Robert S. Vance and concurred in by panel members prior to his death on December 16, 1989.

** Honorable B. Avant Edenfield, U.S. District Judge for the Southern District of Georgia, sitting by designation.

VANCE, Circuit Judge:

Appellant Kenneth Kane appeals the summary judgment entered by the district court in favor of appellees Aetna Life Insurance Company ("Aetna") and Southern Bell Telephone & Telegraph ("Southern Bell"). The district court held that the law of equitable estoppel was preempted in this case by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1401. Because we are of the opinion that equitable estoppel may be applied in this case, we reverse.

I.

Kathy Kane, wife of appellant, first learned of the availability of an infant for adoption approximately ten to fourteen days after the child's birth on May 19, 1984. The child had been born prematurely at Plantation General Hospital and suffered serious medical complications. The Kanes were aware of the child's medical condition. After hearing about the child, the Kanes discussed the possibility of adopting him. The couple realized that without insurance coverage they would be unable to pay for the child's medical expenses.

At the time of the child's birth, appellant was, and continues to be, employed by appellee Southern Bell. After learning of the child and deciding to further investigate the possibility of adoption, the Kanes sought to ascertain whether the Southern Bell Employee Medical Benefit Plan ("Plan"), which covered appellant, would pay for the child's medical expenses. The Kanes did not have a copy of the Plan. On or about May 29, 1984, Mrs. Kane telephoned the Macon, Georgia office of appellee Aetna, which administered the Plan for Southern Bell. Mrs. Kane informed the Aetna customer service representative that she and her husband were interested in adopting a child who was hospitalized at that time. The Aetna representative informed Mrs. Kane that the

child would be covered under the Plan from the date of the commencement of formal legal adoption proceedings.[1]

On June 12, 1984, Maria Almendros, an insurance verifier for the hospital, telephoned Aetna to determine whether the child's medical expenses would be covered under the Plan. Lorrie Knight, an Aetna employee authorized to provide information to callers about coverage under the Plan, told Ms. Almendros that the medical expenses would be covered under the Plan beginning on June 1, 1984. The child remained in the hospital until July 5, 1984, amassing substantial medical expenses.

Appellant filed a claim with Aetna for the child's medical expenses, but Aetna denied the claim. As justification, Aetna cited the provision of the Plan stating that medical expenses for a continuous hospitalization are not covered under the Plan where the hospitalization began prior to the effective date of coverage. Because the formal adoption proceedings did not begin until after the commencement of the infant's hospitalization, Aetna maintained, it was not obligated to pay for any of the medical expenses. *See supra* note 1. As a result of the denial, appellant filed suit against Aetna, basing the action on two theories—equitable estoppel and wrongful denial of a claim.

II.

In its order granting appellee's motion for summary judgment, the district court correctly held that ERISA preempts all state common law claims relating to employee benefit plans, including appellant's equitable estoppel

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[1] Section II of the Plan defines the term "child" to include

> The employee's or retired employee's own children and legally adopted children including those who are in the formal legal process of adoption, regardless of residence.

Plan at 3. The Plan does not define the phrase "formal legal process of adoption."

claim.[2] *See* 29 U.S.C. § 1144(a); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Federal courts possess the authority, however, to develop a body of federal common law to govern issues in ERISA actions not covered by the act itself. *Pilot Life*, 481 U.S. at 56, 107 S.Ct. at 1557. This court has held that the federal common law of equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modifications of employee plans governed by ERISA because ERISA specifically addresses these issues. *Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir.1986) (construing 29 U.S.C. § 1102(a)(1), which requires that employee benefit plans must be "established and maintained pursuant to a written instrument"). The district court found that Aetna's representations to Mrs. Kane and the hospital insurance verifier constituted oral modifications of the Plan. Relying on *Nachwalter*, the court held that all claims based on these modifications were precluded under ERISA.

Appellant asserts that the federal common law of equitable estoppel may be applied in this case because the representations made by Aetna to Mrs. Kane and the hospital were *interpretations* of the Plan, and not modifications. We agree.[3]

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[2] The parties agree that the proper standard of review is *de novo*. In *Firestone Tire and Rubber Co. v. Bruch*, —— U.S. ——, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), the Supreme Court held that district courts should use the *de novo* standard to review denial of employee benefits challenged under 29 U.S.C. § 1132(a)(1)(B) unless the benefit plan gives the administrator discretion to manage the plan. 109 S.Ct. at 956. Both parties agree that Aetna had no discretion in administering the Plan. Although the district court incorrectly applied the "arbitrary and capricious" standard to Aetna's denial of appellant's claim, we find this error to be of no consequence.

[3] We are not unmindful of the rule that estoppel may not be invoked to enlarge or extend the coverage specified in a contract. *See* 18 M. Rhodes, *Couch Cyclopedia of Insurance Law* § 71:40 (Rev. ed. 1983) ("The doctrine of waiver or estoppel cannot be given the

Our conclusion is premised entirely on the language of the Plan itself. The provisions of the Plan at issue here are ambiguous: reasonable persons could disagree as to their meaning and effect. With regard to the effective date of coverage, the Plan specifies that

> Full-time employees (and part-time employees) and their eligible dependents will be covered under the plan on a non-contributory basis, on the first day of the month in which the employee will complete a Term of Employment of six (6) months.
>
> No benefits are covered for charges incurred during a continuous hospital confinement which commenced prior to the effective date of coverage under this plan.

Plan at 2. These provisions clearly are subject to varying interpretations. They may be read as appellees assert—that the "effective date of coverage" language quoted above applies to any person, whether an employee or a dependent of an employee, who claims coverage under the Plan. Consistent with this reading, any person who claims coverage under the Plan for a continuous hospitalization must have been eligible at the commencement of the hospitalization.

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effect of enlarging or extending the coverage as defined in the contract, nor can it create a contract of insurance, since a cause of action cannot be based on a waiver"); *cf.* W. Meyer, *Life & Health Insurance Law* § 9:16 (1971) ("The majority rule has been said to be that while waiver or estoppel may operate to avoid a forfeiture of a policy, it can't change or enlarge the coverage").

This rule embodies the concept that estoppel may not be used to create contractual liability where no contract originally existed. The rule, however, does not apply to the facts of this case, because the application of equitable estoppel will not result in an extension or enlargement of the benefits available under the Plan. The representations made by Aetna amounted to an interpretation of an ambiguous provision of the Plan, not an extension of coverage beyond that specified in the Plan.

The provisions may, however, be construed differently. The "effective date of coverage" language may apply only to the employee. Under this view, once the employee has completed the requisite six-month period, the Plan covers both the employee and his or her dependents. Consequently, the provision that addresses continuous hospitalization is relevant only when the hospitalization commences prior to the completion of the six-month period. *See* W. Meyer, *Life & Health Insurance Law* § 2:4 (1971) (noting the rule with respect to insurance policies that "an ambiguity in the written statement of a contract will be construed against the party who wrote it").

Given this ambiguity, we are of the opinion that these events involved an oral interpretation of the Plan, not an amendment or modification. On two separate occasions, Aetna, acting by and through its duly authorized representative assured appellant and another calling on his behalf that policy coverage applied as of the time formal adoption proceedings were begun. Appellant incured very substantial expenses relying on Aetna's interpretation of an ambiguity within the Plan.

Because the issue before us involves an oral interpretation of an ERISA plan, the *Nachwalter* decision, which is limited to oral amendments and modifications, is not controlling. *See* 805 F.2d at 960. The federal common law of equitable estoppel may be applied to the facts of this case.[4] *See* 2 M. Rhodes, *Couch Cyclopedia of Insur-*

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[4] Other courts have applied the law of equitable estoppel in ERISA cases, *see, e.g., Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1096 (9th Cir. 1985); *Torrence v. Chicago Tribune Co.*, 535 F. Supp. 748 (N.D. Ill. 1982), as well as in comparable situations, *see, e.g., Cann v. Carpenters Pension Trust for Southern California*, 662 F. Supp. 501 (C.D. Cal. 1987) (pension trust claim); *Rosen v. Hotel and Restaurant Employees & Bartenders Union*, 637 F.2d 592, 597-98 (3d Cir.) (same), *cert. denied*, 454 U.S. 898, 102 S.Ct. 398, 70 L.Ed.2d 213 (1981).

ance Law § 15:54 (Rev. ed. 1984) ("An insurer, however, may be estopped in reference to the meaning of a particular term in one of its contracts by its own interpretation of that term"). In reaching this conclusion, we are unpersuaded by appellees' argument that the application of the federal common law of equitable estoppel in this case would be contrary to the underlying policy of ERISA. Requiring appellees to adhere to the oral interpretations of the Plan's provisions made by Aetna to Southern Bell employees will not undermine the integrity of the Plan. Stating the question more broadly, the use of the law of equitable estoppel to enforce oral interpretations of employee benefit plans will not affect the ability of employees and beneficiaries to rely on the written terms of such plans.

Because we find that the federal common law of equitable estoppel may be applied in this case, we REVERSE the district court's order granting summary judgment in favor of appellees and REMAND for further proceedings consistent with this opinion.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 85-6016-CIV-NCR

KENNETH KANE, individually and as Guardian, next friend and on behalf of JONATHON ANDREW KANE, a minor, *Plaintiff*,

vs.

AETNA LIFE INSURANCE COMPANY, etc., *et al.*, doing business in Florida

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ORDER

[Filed Oct. 12, 1988]

THIS CAUSE is before the Court on motion of Defendants SOUTHERN BELL TELEPHONE AND TELEGRAPH COMPANY ("Southern Bell") and AETNA LIFE INSURANCE COMPANY ("Aetna") for Summary Judgment. The Court's analysis and judgment are fully set out below.

The undisputed facts of this cause as taken from the Complaint and answer show that JONATHON ANDREW KANE (the minor) was born May 19, 1984 at Plantation General Hospital, Broward County, Florida. The minor was ill at the time of his birth, and extensive medical treatment was required. The duration of the medical treatment spanned from the minor's birth, May 19, 1984, to July 5, 1984. The minor remained hospitalized during the treatment period.

Plaintiff, KENNETH KANE, and his wife (the "Kanes") became interested in adopting the minor at some time after the minor's birth, but prior to the minor's discharge. Although the actual date the adoption proceedings began is in dispute, the exact date has no effect on this Court's determination of Defendant's Motion for Summary Judgment. For the purposes of this order, the Court rules that the adoption proceedings formally began on May 31, 1984.

KENNETH KANE is now and at all times prior to and during the events leading to the bringing of this cause, an employee of Defendant Southern Bell. As such, it is undisputed that the Kanes were and are, covered under the Employee Medical Benefit Plan (the "Plan") funded by Southern Bell and administered by Defendant Aetna.

The Court accepts as true the Kanes' allegation that they wanted to adopt the minor, but would not have done so unless the minor's medical bills were covered under the Plan. The Kanes were aware of the substantial medical and hospital expenses incurred for the care of the minor, and the likelihood of greater medical expenses which would accrue in the future. As such, the Kanes endeavored to contact Aetna to determine if the minor would be covered by the Plan through one Maria Almendios, an insurance verifier at Plantation General Hospital.

The Kanes allege, and this Court takes the same as being true, that Ms. Almendios contacted Aetna's offices in Macon, Georgia by telephone on June 12, 1984, to determine if coverage extended to the minor. Ms. Almendios spoke with one Lori Knight, an employee of Aetna who was authorized to provide information to authorized callers regarding coverage under the Plan. Ms. Almendios spoke with Ms. Knight on June 12, 1984 and was orally assured that the minor would be covered from June 1, 1984 forward.

The Kanes allege that as a result of Ms. Knight's oral representations, they initiated adoption proceedings. The Court, without basing its decision upon the fact, notes that the Kanes' claim of dependence upon Ms. Knight's representations is somewhat incongruous given the fact that Ms. Knight's statements were made at a time later than the institution of the adoption proceedings.

The Kanes subsequently presented the minor's hospital bills to Aetna for payment. Aetna has refused to pay, giving rise to this action. Plaintiffs base their cause solely upon the claim that Ms. Knight's representations obligate Aetna and Southern Bell to pay the minor's medical and hospital bills accruing after June 1, 1984. The Kanes seek coverage of the minor as a dependent. The provisions of the Plan relevant to this cause are set out below.

II—Eligibility—General Definitions defines dependent coverage:

> An employee's dependent is any person in the eligible dependent classes.
>
> The eligible dependent classes are
>
> > DEPENDENT CLASS I—[A]ny unmarried child of [a covered] employee . . . until December 31 of the year in which such child attains nineteen (19) years of age.
>
> The term "child" will include:
>
> > a. The employee's . . . legally adopted children including those who are in the *formal* legal process of adoption, regardless of residence. (emphasis added.)

The Plan contains several General Exclusions. In Section III—Description of Benefits, the following language appears:

GENERAL EXCLUSIONS:

This Plan does not provide coverage for any of the following:

Charges incurred as to a person while he is not a covered family member.

Charges that no person, to whom coverage relates, is legally obligated to pay.

Charges incurred during a continuous hospital confinement which commenced prior to the effective date of the individual coverage under this Plan.

To summarize, the Plan does cover adopted children. However, the Plan does not cover charges incurred when the adopted child is not in the formal legal process of being adopted. Further, the Plan excludes coverage of charges incurred during a continuous hospital confinement, commencing prior to the effective date of the adopted child's coverage under the Plan. Therefore, in the case at bar the minor is clearly excluded from coverage under the Plan, as the minor was not in the formal legal process of adoption until weeks after his birth. Under the terms of the Plan, the minor would only be covered for charges incurred after the date the continuous hospitalization terminated, that being July 5, 1984.

Thusly, the crux of the Kanes' cause must necessarily turn on the validity, and binding effect of Ms. Knight's representations to the Kanes, through Ms. Almendios. At first blush the question would seem to be a matter of state law. However, the Court is compelled by the holding of the Supreme Court of the United States in *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. 1549 (1987) to find that the Kanes' State common law cause of action is pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

ERISA comprehensively regulates employee welfare benefits plans that provide medical, surgical or hospital

care "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(i); *Dedeaux*, 107 S.Ct. at 1551. Congress expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Thus, Congress has deliberately designed ERISA to be an area exclusively of federal concern. *Dedeaux*, 107 S. Ct. at 1552. In *Dedeaux*, as here, State common law causes of action regarding employee welfare benefits must give way to pre-emption by ERISA. *Id.* 107 S.Ct. at 1553; *See Howard v. Parisian*, 807 F.2d 1560 (11th Cir. 1987).

As such, the fundamental question facing the Court is whether Ms. Knight's oral assurances of coverage are enforceable against Aetna or Southern Bell. Under ERISA, the answer to the question is most assuredly "NO". *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986). ERISA specifically addresses the point, expressly requiring that employee benefit plans must be "established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Therefore, oral modification of the Plan is precluded. *Nachwalter*, 805 F.2d at 960. It likewise follows that the common law doctrine of estoppel cannot alter the result. *Id.* In the clear light of *Nachwalter*, and the guidance it provides the Court as the law of this Circuit, the Court holds that the oral assurance of coverage made by Ms. Knight is invalid and not binding on either Defendant.

The clear weight of authority in this circuit is that the actions of ERISA administrators must be sustained as a matter of law unless plaintiff can prove the administrator's activities are arbitrary and capricious. *Chilton v. Savannah Foods & Industries, Inc.*, 814 F.2d 620, 624 (11th Cir. 1987). The Court finds that Aetna, as administrator of the Plan, did not act arbitrarily or capriciously in denying the Kanes coverage. The Defendants are thereby entitled to a judgment as a matter of law. The Kanes' cause is pre-empted by federal law and not

maintainable under the requirements of that federal law. Therefore, it is,

ORDERED AND ADJUDGED that Defendants' Motion for Summary Judgment is GRANTED.

DONE AND ORDERED this 7 day of Oct., 1988.

/s/ Norman C. Roettger, Jr.
NORMAN C. ROETTGER, JR.
United States District Judge

cc: Counsel of Record

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Case No. 88-6148

KENNETH KANE, individually and as Guardian, next friend and on behalf of JONATHAN ANDREW KANE, a minor, *Appellants*,

v.

AETNA LIFE INSURANCE COMPANY, a Connecticut corporation, doing business in Florida, and SOUTHERN BELL TELEPHONE & TELEGRAPH COMPANY, *Appellees*.

On Appeal from the United States District Court
for the Southern District of Florida,
Fort Lauderdale Division

SUGGESTION FOR REHEARING EN BANC

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CERTIFICATE OF INTERESTED PERSONS

The persons or parties having an interest in the outcome of this case include:

The Honorable Norman C. Roettger, Jr., United States District Judge, Southern District of Florida.

Aetna Life Insurance Company.

Southern Bell Telephone & Telegraph Company.

BellSouth Services, Inc.

Kenneth Kane, Kathy Kane, and Jonathan Kane.

Plantation General Hospital.

John R. Hargrove, Esquire, Lillian P. Wolf, Esquire, Heinrich Gordon Batchelder Hargrove Weihe and Gent.

Richard H. Levenstein, Esquire, James G. Leech, Esquire, Bond, Schoeneck & King.

STATEMENTS OF COUNSEL

I express a belief, based on a reasoned and studied professional judgment, that the panel decision is contrary to the following decisions of the Supreme Court of the United States or the precedents of this circuit and that consideration by the full court is necessary to secure and maintain uniformity of decisions in this court:

Pilot Life Insurance Co. v. Dedeaux,
481 U.S. 41, 95 L. Ed. 2d 39 (1987).

Nachwalter v. Christie,
805 F.2d 956 (11th Cir. 1986).

I express a belief, based on a reasoned and studied professional judgment, that this appeal involves one or more questions of exceptional importance:

1. Whether a participant of an ERISA plan can state a cause of action under the federal common law of estoppel to force the plan administrator to pay benefits?

2. Whether the integrity of ERISA plans are violated where "informal" statements as to the extent of coverage, made by an employee of the plan administrator over the telephone, are deemed binding?

/s/ John R. Hargrove, Esquire
JOHN R. HARGROVE, ESQUIRE
Attorney of Record for Appellees

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STATEMENT OF THE ISSUES

I

WHETHER A PARTICIPANT OF AN ERISA PLAN CAN STATE A CAUSE OF ACTION UNDER THE FEDERAL COMMON LAW OF ESTOPPEL TO FORCE THE PLAN ADMINISTRATOR TO PAY BENEFITS?

II

WHETHER THE INTEGRITY OF ERISA PLANS ARE VIOLATED BY ALLOWING INFORMAL TELEPHONE EXCHANGES REGARDING COVERAGE, MADE BY AN EMPLOYEE OF THE PLAN ADMINISTRATOR, TO BE BINDING?

COURSE OF PROCEEDINGS AND DISPOSITION OF THE CASE

This case involves an employee who is attempting to recover medical benefits under an employee welfare benefit plan controlled by ERISA by asserting a cause of action based on estoppel. The key fact to finding coverage relates to an informal telephone representation of an employee of the plan administrator. The finding is contrary both to settled federal case law and statutory requirements mandating strict construction of ERISA plans.

STATEMENT OF THE CASE

Kenneth Kane, individually and as Guardian, next friend and on behalf of Jonathan Andrew Kane, ("the Kanes") sued Aetna Life Insurance Company ("Aetna") and Southern Bell Telephone & Telegraph Company ("Southern Bell") for damages for refusal of Aetna to pay benefits under a welfare plan. On November 18, 1986, Aetna and Southern Bell moved for summary judgment, judgment, or partial summary judgment and filed a supporting memorandum of law. (R.1-26-1; 1-27-1) The motion states that the Kanes are not entitled to

recover because of the clear and unambiguous language of the Employee Medical Benefit Plan ("the plan"). Nearly two years later on October 8, 1988, the District Court granted a final summary judgment. (R.2-56-1) This Court reversed.

STATEMENT OF THE FACTS

The undisputed facts for purposes of this petition are as follows. Kenneth Kane was a BellSouth employee who was covered under the company's ERISA plan. Mr. Kane received a written summary plan which described the benefits of the plan. One paragraph of the summary states:

> The information contained in this booklet describes only the highlights of the Medical Expense Plan. It is a Summary Plan Description as defined by the Employee Retirement Income Security Act of 1974 (ERISA). It does not attempt to cover all details. These are contained in the master contract between Aetna Life Insurance Company and the Company which legally governs the operation of the Plan. . . . *Upon written request addressed to Corporate Secretary, Southern Bell Telephone and Telegraph Company . . . any or all of these documents will be furnished to a Plan participant or dependent within 30 days at a reasonable charge.* (R.2-50-Ex. B, p. 28) (Emphasis added)

The summary plan also states:

> Once you complete six months of service as a regular full-time employee, your coverage is *automatic* beginning the first of that month. Dependents are covered effective the same date or the date eligibility requirements are met provided you have enrolled them. (plan at 9)

The summary plan states that plan participants may examine the plan at the plan administrator's office and

at other specified locations. Both the master contract and the summary plan state that continued hospital confinement which commences prior to the effective date of the plan coverage, and charges for services received before dependents are covered under the plan, are excluded from coverage. One section of the plan provides that a covered child includes *legally adopted children*, including "those who are in the formal legal process of adoption, regardless of residence." (R. 1-13-Ex. A) The plan expressly *excludes* coverage for charges incurred during a continuous hospital confinement *which commenced prior to the effective date of the individual coverage.*

The minor, Jonathan Kane, was born prematurely at Plantation General Hospital on May 19, 1984. He suffered from serious medical illnesses. Jonathan's natural mother had decided to give the child up for adoption. Shortly after his birth, Mr. and Mrs. Kane learned about Jonathan and were interested in adopting him. They decided, however, that they could not do so unless his hospital stay would be covered by the plan. On May 29, 1984, Mrs. Kane called the toll free number contained in the summary plan to ascertain whether Jonathan's expenses would be covered. Mrs. Kane asked for someone who could give her information regarding coverage under the plan. Aetna's representative told her that "any adopted child would be covered." On June 12, 1984, Marie Almendros, an employee at Plantation General Hospital, telephoned Aetna. She spoke with Lori Knight, who advised Ms. Almendros that Jonathan would be covered.

On the date he was born, Jonathan was not a covered child. The Kanes had not known of him until several days later, so had not yet consented to adopting him.[1]

---

[1] The Kanes assert that Jonathan was in the formal legal process of adoption from the moment of his birth because his natural

Jonathan was hospitalized continuously from the date of his birth until July 5, 1984.

Mr. and Mrs. Kane adopted Jonathan and thereafter Aetna denied their claim. They filed suit alleging two counts—wrongful refusal to extend coverage under the contract and equitable estoppel. The trial court granted summary judgment in favor of the defendants, finding that ERISA expressly requires that employee benefit plans must be established and maintained pursuant to a written instrument, and therefore, *oral assurances of coverage are unenforceable.* Additionally, the trial court found that the terms of the plan clearly excluded coverage. It did not find that any ambiguities existed.[2] This Court reversed, however, finding that the federal common law of estoppel may be asserted to enforce oral representations where the language of the plan is ambiguous. The decision conflicts with precedent set by the United States Supreme Court and a prior decision of this circuit, and presents a question of exceptional importance dealing with the administration of ERISA plans generally.

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mother had already agreed to give him up. This argument has no merit since the Kanes could not have been in the process of adopting Jonathan even before they knew of his existence.

[2] The Kanes have apparently abandoned their "wrongful denial of benefits claim." They addressed only the estoppel issue on appeal.

ARGUMENT AND AUTHORITIES

I

A PARTICIPANT OF AN ERISA PLAN CANNOT STATE A CAUSE OF ACTION UNDER THE FEDERAL COMMON LAW OF ESTOPPEL TO FORCE THE PLAN ADMINISTRATOR TO PAY BENEFITS.

The United States Supreme Court has determined the *only* causes of action that an ERISA beneficiary may bring in its decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39 (1987). The sole issue in *Pilot Life* was whether ERISA preempts state common law tort and contract actions asserting improper processing of a claim for benefits under an employee benefit plan. The plaintiff, Dedeaux, injured his back in an accident related to his employment. Dedeaux claimed benefits under the long term disability employee benefit plan that his employer had purchased from Pilot Life Insurance Company. Pilot Life was responsible for determining who was eligible for benefits. When Pilot Life terminated Dedeaux's benefits, he filed suit based on claims of breach of contract, breach of fiduciary duties and fraud in the inducement. "Dedeaux did not assert any of the several causes of action available to him under ERISA." 95 L.Ed.2d at 45. The district court granted summary judgment in favor of Pilot Life, finding that all of Dedeaux's claims were preempted.

In its opinion, the Court notes these specifics about ERISA. First, ERISA *comprehensively* regulates employee welfare benefit plans. *Id.* at 46. The express provisions of ERISA are deliberately expansive, and are designed so that pension plan (and any ERISA plan) regulation is an *exclusively federal concern. Id.* Second, the Court agreed with the argument of the Solicitor General that Congress clearly expressed an intent that the civil enforcement provisions of ERISA section 502(a) be

the *exclusive* vehicle for actions by ERISA-plan participants and beneficiaries. *Id.* at 50-51. The Court stated:

> The conclusion that section 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of section 502(a) was modeled on the exclusive remedy provided by section 301 of the Labor-Management Relations Act.

Id. at 51. The Court then went on to state the following regarding the manner in which plan benefits must be determined:

> Under the civil enforcement provisions of section 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, *a declaratory judgment on entitlement to benefits*, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty. . .
>
> In sum, the detailed provisions of section 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in section 502(a) of the statute as finally en-

> acted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." [citing *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985).]
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that *ERISA's civil enforcement remedies were intended to be exclusive.* This conclusion is fully confirmed by the legislative history of the civil enforcement provision. [emphasis added]

Id. at 51-52. Finally, the court stated:

> Congress' specific reference to section 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by section 502(a).

Id. at 53. The whole point is that *Pilot Life* severely limits and restricts the causes of action that a person may bring to determine their entitlement to benefits. Clearly, in this case the Kanes are claiming that Aetna improperly processed their claim. *That means that no common law cause of action for estoppel existed.* The Kanes' only proper method of recourse was to file a declaratory action for determination of benefits, as specified in *Pilot Life*.

Although *Pilot Life* addresses state common law causes of action, its holding applies equally to the situation presented here. *The Court delineated a narrow category of remedies.* By its ruling that the Kanes may assert a cause of action under the federal common law of estoppel,

the court's decision as it now stands expressly conflicts with *Pilot Life*. Indeed federal common law may be applied to govern federally preempted areas, *but only where the federal statute does not expressly address the issue before the court. See Holland v. Burlington Industries, Inc.*, 772 F.2d 1140 (4th Cir. 1985). That is not the case here. The facts presented fall squarely within one of the categories of causes of action enumerated under *Pilot Life*. If a question as to coverage existed, a declaratory judgment action should have been maintained. At first blush this case evokes sympathy for the adoptive parents who claim that they would not have adopted Jonathan had there been no coverage. However the Kanes *knew* of the child's health problems before deciding on adoption. *And at that point they should have been relegated to the same standards under Pilot Life as anyone else seeking a policy interpretation regardless of the circumstances.* The Court in *Pilot Life* stated that remedies as to *enforcement* and *interpretation* are *exclusive*. Therefore, the federal statute addresses the issue before the court. The court is absolutely prohibited from turning to the federal common law for guidance where a remedy exists.

II

THE INTEGRITY OF ERISA PLANS ARE VIOLATED BY ALLOWING INFORMAL ASSURANCES OF COVERAGE, MADE BY AN EMPLOYEE OF THE PLAN ADMINISTRATOR, TO BE BINDING.

The panel decision holds that a beneficiary may be entitled to rely on oral representations if he can establish the elements of estoppel. This holding not only conflicts with *Pilot Life*, but also conflicts with this court's own decision in *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986). The question in *Nachwalter* was whether the federal common law of estoppel could be used to enforce an oral modification of an ERISA plan. The trial

court entered summary judgment in favor of the plan administrators, holding that neither oral agreement nor "*informal exchange*" may be used to modify the written terms of the plan. *Nachwalter v. Christie*, 611 F. Supp. 655 (S.D. Fla. 1985). *The Eleventh Circuit affirmed that ruling.*

The key to *Nachwalter* is that *any* informal representations, *including those made by telephone*, will not be binding. *The summary plan in this case provides its beneficiaries with the name and address of the corporate secretary to whom questions must be directed.* This procedure is designed to protect the integrity of the plan as well as the rights of its participants. Allowing "informal" representations of the plan administrator's employee to act as a binding interpretation of the plan undermines the purposes of ERISA in requiring a fiduciary administrator to determine who is to receive benefits. And, by applying the federal common law of estoppel, which is adopted from the law of the state in which the circuit sits, the uniformity of administration is undermined because the beneficiary's rights will depend upon an interpretation of state law. *This is precisely the evil Congress was attempting to avoid when it declared that ERISA would preempt state law.*

The court nevertheless attempts to distinguish *Nachwalter* by finding that in this case the administrator was *interpreting* an ambiguous provision of the plan, rather than *modifying* it. First of all, the district court in *Nachwalter* expressly threw out "informal exchanges" as a means of finding a basis for estoppel because that type of reasoning is what *Pilot Life* and Congress proscribes. Second, to find that the plan was ambiguous, this court must have improperly applied the state common law standard of review with respect to construing contracts against the drafter. Indeed the trial court found that the plan was clear and unambiguous. *Northwest Administrators, Inc. v. B.V. & B.R., Inc.*, 813 F.2d 223, 226

(9th Cir. 1987). Plain and simply, estoppel cannot be applied under any circumstances to authorize payment under a written plan where coverage does not exist.

What obviously happened here is that the court wanted to find coverage and found it without giving proper deference to *Pilot Life* and the cardinal rule of strict construction without resort to state law. This is obvious from the opinion itself. The plan provides that employees *and their dependents* are not covered for continuous hospitalizations beginning prior to the effective date of coverage. It also provides that dependent coverage becomes effective on the date eligibility requirements are met *provided dependents have been enrolled.* The record fails to establish that at the time coverage inquiries were made, Jonathan was enrolled at all. Naturally he was not enrolled because the Kanes themselves decided that enrollment would be a "condition precedent" to adoption. The interpretation given by the court nonetheless allows an employee to adopt a child and render the plan responsible for benefits without regard to the strict construction ERISA requires. Thus, the panel decision conflicts with the holding and policies contained in *Pilot Life* and *Nachwalter*, as well as the purposes and policies behind the ERISA legislation.

CONCLUSION

The panel decision conflicts with the decisions of the United States Supreme Court and a decision from this district. Because the issue involved concerns administration of an ERISA-plan, which Congress has deemed to be important enough to be federally preempted, the appeal involves an issue of exceptional importance. The appellees respectfully request this court to take jurisdiction of this suggestion for rehearing en banc to reverse the panel decision so that it complies with the mandates of the United States Supreme Court.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the above and foregoing suggestion for rehearing en banc has been served by United States mail postage prepaid on: Richard H. Levenstein, Esquire and James G. Leech, Esquire, Attorneys for Appellants, Bond, Schoeneck & King, Crocker Plaza, Suite 1002, 5355 Town Center Road, Boca Baton, Florida 33486 on this 26th day of February, 1990.

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APPENDIX D

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 88-6148

KENNETH KANE, individually and as
Guardian, next friend & on behalf
OF JONATHAN ANDREW KANE, A Minor,
Plaintiff-Appellant,

versus

AETNA LIFE INSURANCE and
SOUTHERN BELL TELEPHONE & TELEGRAPH,
Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Florida

ON PETITION(S) FOR REHEARING AND
SUGGESTION(S) OF REHEARING EN BANC
(Opinion February 7, 1990, 11 Cir., 198–, — F.2d —).
(April 6, 1990)

Before VANCE * and COX, Circuit Judges, and EDENFIELD **, District Judge.

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* Judge Robert S. Vance did not participate in consideration of this petition for rehearing and suggestion of rehearing en banc due to his death on December 16, 1989.

** Honorable B. Avant Edenfield, U.S. District Judge for the Southern District of Georgia, sitting by designation.

PER CURIAM:

(X) The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ [Illegible] R. Cox
United States Circuit Judge

APPENDIX E

SUMMARY PLAN DESCRIPTION

MEDICAL EXPENSE PLAN

[Emblem Omitted in Printing]

JANUARY 1, 1982 SOUTHERN BELL

INTRODUCTION

The Medical Expense Plan is designed to provide you and your eligible dependents with comprehensive coverage for the cost of medical care. It pays benefits for just about any type of medical care or treatment you'll ever need—all during your active employment and after you retire.

The Plan has also been designed to make it easy for you to use. There's just one form to fill out each time you claim covered expenses.

There are also special provisions within the Plan which are designed to control costs by giving you certain choices about how and where to seek medical care. You are urged to learn about these provisions and to make use of them whenever you can.

The Plan is classified under the definition of the Employee Retirement Income Security Act of 1974 as a "welfare plan." The effective date of the Medical Expense Plan is January 1, 1982. Key features of the Plan are explained on the following pages.

PLAN HIGHLIGHTS

Your Medical Expense Plan pays a substantial share of the costs of the medical care and services you and your family receive each year—as much as *100%* in many cases. Just how much is paid depends on the type of care received.

The following table shows how much is paid by the various parts of the Plan.

FOR THESE EXPENSES	THE PLAN PAYS
• HOSPITAL CARE	
—Inpatient Services	
—*Semi-private* room, board, and services including intensive care and cardiac units	*100%* for up to 120 days for each separate stay for most conditions.

—*Private room* (if hospital has *only* private rooms)	*90%* for up to 120 days for each separate stay for most conditions.
—Outpatient Services (Billed by hospital)	*100%* of the reasonable and customary charge if treatment is given: —within 72 hours after an accident or the onset of a sudden and serious illness *or* —for minor surgery at any time.
—Ambulatory Surgical Facility	*100%* of the reasonable and customary charge
—Pre-Admission Testing	*100%* of the reasonable and customary charge for diagnostic laboratory and X-ray examinations performad prior to surgery under an approved program.

• SURGICAL CARE

—Surgery	*95%* of the reasonable and customary charge.

• MEDICAL CARE

—Second Surgical Opinions —Diagnostic X-rays and Lab Tests —Radiation Therapy —Electroshock Therapy	*100%* of the reasonable and customary charge—subject to certain limitations described later in this booklet.
—Administration of Anesthesia —In-Hospital Doctors' Visits —In-Hospital Consultations (i.e., your doctor with a specialist)	*90%* of the reasonable and customary charge—subject to certain limitations described later in this booklet.

• ALCOHOLISM TREATMENT PROGRAM FOR REHABILITATION	*100%* of charges for inpatient care if received in an approved program—up to 30 days of each separate stay. Benefits limited to two stays and apply only to you and members of your immediate family (i.e., your Class I dependents).
• "OTHER COVERED CHARGES"	After you meet your deductible . . . *80%* of the reasonable and customary charges for most other covered expenses—except certain non-hospital psychiatric care—until "Other Covered Charges" total *$5,000*, then . . . *100%* of any remaining covered expenses for the rest of that calendar year—except for certain non-hospital psychiatric care. *For non-hospital psychiatric care*, the Plan pays 50% unless you (the employee) are the patient and are out of work due to mental disability, in which case the Plan pays 80% or 100%—depending on the amount of "Other Covered Charges" incurred.
• MAXIMUM BENEFITS UNDER "OTHER COVERED CHARGES"	*Unlimited benefits* for you during your *active* employment and for each of your covered dependents then under age 65. *$50,000 in lifetime benefits* for you during *retirement* and for each of your covered dependents.

All dependents over age 65 —whether you are an active employee or retired— are subject to the $50,000 life-time maximum.

The first $3,500 of benefits each calendar year is *not* applied toward this maximum.

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TO HELP YOU UNDERSTAND

. . . How your Medical Expense Plan works, it's important you know what the following terms mean as used in this booklet.

Ambulatory Surgical Facility is an institution in which you can have surgery performed without an overnight stay. Many different types of surgical procedures can be performed in these facilities at less cost—and inconvenience—than if you were a hospital inpatient. The facility need not be part of a hospital, but it must be permanently equipped and operated primarily to provide surgical services. A doctor's or dentists's office is *not* considered such a facility.

Annual Basic Pay—one which your and each of your dependents' deductibles are based—is 52.2 times your normal weekly base pay, of 12 times your monthly base pay for the last pay period of the preceding calendar year. If you were not on the payroll at the end of the year, it's your pay rate during the last pay period before you became insured. Annual basic pay does not include temporary differentials or extra payments.

For retired employees the annual basic pay means the amount of "annual pension" being paid in accordance with the terms of the Bell System Pension Plan or the Bell System Management Pension Plan.

Covered Expenses means the charges for those medical services and supplies that qualify for full or partial payment under the Plan. Charges qualify for payment to the extent that they are *reasonable* and *customary*. In addition they must be performed or ordered by a doctor. *Reasonable* and *customary* means that the fee is what your doctor usually charges most patients for a similar service and that it falls within the range charged by doctors with comparable training and experience for the same or similar services within the locality. Also taken

into account are your condition and any additional time or special skills needed by your doctor to treat you.

Deductible means the amount you pay in a calendar year before the Plan pays benefits for "Other Covered Charges."

As an *active* employee, your deductible equals 1% of your annual basic pay; as a *retired* employee, 1% of your annual pension benefit. In either case, your individual deductible is never more than $150 or less than $25 each calendar year.

The deductible also applies each calendar year to claims for each of your covered dependents. However, no family need meet more than three deductibles in any calendar year—nor more than one in any calender year for all expenses caused by an accident involving two or more family members. What is more, any expenses incurred during the last three months of the year which are applied to an individual or family deductible can be carried over and reused to satisfy the next year's deductible as well.

Dependent means a family member who qualifies for the protection provided by the Plan. Coverage is made available to your:

- Class I Dependents—your spouse and your unmarried children until the end of the year in which they reach age 19, or until the end of the year in which they reach age 23 if full-time students, or any unmarried child, regardless of age, who is physically or mentally handicapped and fully dependent on you for support. Children include your own children, legally adopted children, and, if they live with you, stepchildren or children for whom you or your spouse are legal guardian.
- Class II Dependents—your unmarried children who are not Class I dependents, your unmarried grandchildren, your brothers and sisters, and the parents and grandparents of you and your spouse, if they have lived with you or in a household pro-

vided by you in the vicinity for at least six months. In addition, to qualify for coverage, the total income of a Class II dependent—not counting any support you provide—must be less than *$6,000* a year from all sources including Social Security.

- A Sponsored Child—an unmarried child, age 19 or older who is not a full-time student. You can sponsor such a child for coverage until the end of the year in which he or she reaches age 23, whether the child resides with you or not and regardless of how much income he or she is receiving. You pay for this coverage—the full individual rate charged by the insurance carrier—and you must apply for it by contacting your Area Benefit Office.

Employee—any full- or part-time regular employee so classified by the Company for payroll purposes.

Hospital means a legally constituted institution which provides 24-hour nursing services and maintains on its premises the equipment, space and supplies needed to provide diagnosis and treatment of ill or injured people by or under the supervision of a staff of physicians. Psychiatric hospitals which are accredited by the Joint Commission on the Accreditation of Hospitals are considered to be hospitals under this Plan. (Convalescent homes, nursing homes and other facilities which primarily provide nursing, custodial, or rest care—or care for the aged—do not qualify as hospital under the Plan.)

Medicare is a program sponsored by the Social Security Administration which provides benefits toward the cost of medical care. There are two parts to the program:

- *Part A*—which provides benefits for hospital care

and

- *Part B*—which provides benefits toward doctors' fees and certain other covered medical expenses.

You and your dependents become eligible for both parts of Medicare upon reaching age 65—or before age 65 if disabled and 24 months of disability payments have been received from Social Security. Medicare is also available at any age—and without the need to prove disability—if the individual has chronic kidney disease and requires dialysis or a kidney transplant.

Part A costs you nothing. For Part B, the government charges a monthly premium. However, the Company will reimburse the basic premium you pay to the government for Part B coverage if you are eligible and apply to your Area Benefit Office.

Physician or Surgeon is an individual who is licensed to prescribe and administer drugs and perform surgery. A physician under the Plan also includes:

- *dentist*—when operating within the scope of his or her license and while providing certain services covered by the Plan
- *podiatrist*—if duly licensed and operating within the scope of his or her license when performing certain covered services common to medicine and podiatry, and
- *psychologist*—if certified and registered—and when providing psychological services in connection with the diagnosis or treatment of a mental or nervous condition.

Retired employee—a former employee who has retired with a Service Disability Pension Under the Bell System Pension Plan or the Bell System Management Pension Plan. A former employee who qualifies only for a deferred vested pension is not considered a retired employee.

Sudden and Serious Illness means a condition that requires immediate and urgent medical attention such as:

—acute appendicitis
—asthmatic attack
—drug overdose
—food poisoning
—frostbite
—hemorrhage
—hysteria
—an object stuck in the eye, ear, nose or throat

. . . or any other condition of similar severity.

ELIGIBILITY

As a regular, full-time or part-time employee of the Company, you are eligible to participate in this Plan. Your dependents are eligible, too.

Retired employees and their dependents are also eligible—see page 22 for more details about this coverage.

WHEN COVERAGE STARTS

If you are a new employee, you can enroll for individual or family coverage in the Plan within 31 days after you are hired by paying the full cost of the coverage. Coverage will be effective on the first of the month after the Company receives your application. Enrollment forms are available from your Area Benefit Office.

Once you complete six months of service as a full-time employee, covereage is *automatic* beginning the first of that month.

COST

If you are a full-time employee—or a part-time employee whose scheduled equivalent work week classification is 25 or more hours—the Company pays the full cost of coverage beginning the first of the month in which you complete six months' service.

If enrolled, part-time employees whose scheduled equivalent work week classification is between 17 and 24 hours pay half the cost of their coverage; if their schedule is 16 hours or less a week, they pay for it all.

However, the Company will continue to pay the full cost of coverage for part-time employees hired before January 1, 1981.

PLAN BENEFITS

The Plan pays benefits for a broad range of medical services and supplies all during your active employment and after you retire. Here's what's provided:

—Hospital Care
—Surgical Care
—Medical Care
—Alcoholism Rehabilitation

—plus—

—Benefits for "Other Covered Charges"

Together, these benefits provide important financial protection for just about any type of medical expenses you may have—hospital, surgical, maternity, well-baby care, emergency care, doctors' visits, in-hospital consultations, lab tests, X-rays, prescription drugs, private-duty nursing services and various forms of therapy.

HOSPITAL CARE BENEFITS

This part of the Plan pays benefits for inpatient and outpatient hospital care, plus pre-admission tests and the services of an ambulatory surgical facility.

Inpatient Care

For each hospital stay—either for you or one of your dependents—Hospital Care Benefits pay:

—the *full* cost of semi-private room, board and other hospital services including charges for the use of intensive care and cardiac care units

—for up to *120* days.

If the hospital you enter only has private rooms, you will still be covered for up to 120 days for each separate

stay. However, the benefit will be *90%* of the most prevalent private room rate. You pay the difference.

For certain conditions—as explained below—the Plan *limits* the number of days benefits are paid. However, for each day that is covered, benefits are also paid in *full* based on the hospitals's semi-private room rate.

Other hospital services include:

- use of operating, delivery and recovery rooms plus special equipment
- drugs, dressings, splints, oxygen and medicines
- general nursing care
- lab tests and X-rays
- radiation therapy and treatment
- special diets
- physical therapy
- anesthesia
- administration of blood (but not the cost of the blood itself).

Hospital benefits for inpatient care are limited to 120 days for each separate stay. If you enter the hospital again after you've been out at least 90 days—or for a new condition regardless of when you were last discharged—that next stay is considered completely separate from the previous one. Benefits are payable for another 120 days. But if you reenter the hospital within 90 days for the same or related condition, benefits will be paid only for the number of days you have left from your previous stay.

Although it's pretty unlikely, you could remain in the hospital for more than 120 days. If you do, coverage is provided for our continued care through benefits for "Other Covered Charges"—see page 12.

Special Limitations

For the treatment of a mental or nervous condition, alcoholism, or drug addiction, hospital benefits are limited to *30* days for each separate confinement. In these cases, each stay must be separated by at least *180* days or it will be considered a continuation of the previous one.

Other important points. If you enter a hospital as an inpatient primarily for diagnostic studies, laboratory tests or physical therapy, *no* benefits will be paid toward your room and board charges. The tests will be covered under "Medical Care Benefits"—see page 10—at 90% of the reasonable and customary charge, but that's all. You pay the difference. This type of care can be provided other than on an inpatient basis at a big cost savings to you. In fact, you can have diagnostic X-rays and lab tests performed in the hospital's outpatient department at no cost to you at all.

Hospitalization for dental care is covered only if confinement results from accidental bodily injury, or when a physician other than a dentist certifies that hosptialization is necessary to safeguard the life or health of the patient.

Outpatient Care

Hospital Care Benefits also pay the *full* cost of all reasonable and customary *hospital charges* for treatment received in a hospital outpatient department for:

—minor surgery, diagnostic X-rays and laboratory tests—at any time

—emergency first-aid—received within 72 hours after an accident or the onset of a sudden and serious illness. It is not intended that benefits be paid under this section of the Plan if the hospital emergency room is used as a substitute for a doctor's office visit.

Pre-Admission Testing

The Plan also pays *100%* of the reasonable and customary charges for diagnostic laboratory and X-ray examinations performed under a program of pre-admission testing. These tests are conducted within a few days before you enter the hospital as an inpatient for a surgical procedure.

Services of an Ambulatory Surgical Facility

The Plan pays *100%* of the reasonable and customary charges billed to you by an ambulatory surgical facility. These charges will be for the use of the facility and for services similar to those that would be paid on an inpatient basis. (Your surgeon's bill will be separate and will be reimbursed under Surgical Care Benefits described next.)

Since surgery in one of these facilities doesn't require an extended stay, the overall cost is far less than if you had the surgery performed while a hospital inpatient. If the surgery you need permits it—and there is such a facility available—your doctor will know.

SURGICAL CARE BENEFITS

This part of your Plan pays *95%* of your surgeon's reasonable and customary charge for any covered surgical procedure he or she performs. When the surgery is performed in a hospital, and the services of an assistant surgeon are also necessary, his or her fees are also paid at 95%. Post-operative care provided by your surgeon or another physician is included regardless of where the operation takes place. The remaining 5% of the reasonable and customary charge will be automatically considered under "Other Covered Charges"—see page 12.

Surgical Care Benefits are *not* payable for dental surgery. Nor are they payable for cosmetic surgery except to restore features damaged in an accident which occurs

while you're covered under the Plan—or to correct birth defects.

MEDICAL CARE BENEFITS

These benefits pay for a wide variety of services performed by a physician other than your surgeon.

Medical Care Benefits payable at *100%* of the reasonable and customary charges are:

- Second Surgical Opinion (including any required diagnostic X-rays or pathology tests). Benefits are paid for a pre-surgical consultation with another qualified specialist, following a current recommendation of elective surgery, but only if you request the consultation and the specialist is a physician approved by the Plan. Benefits will also be paid for an additional consultation if the first two physicians don't agree. Your surgeon will be familiar with this provision, so be sure to ask.
- X-Ray Examinations and Lab Tests including Pap Smears (but not the physician's office visit charge). No benefits are paid for dental X-rays or for tests covered under the hospital portion of the Plan.
- Radiation Therapy and Treatment
- Chemotherapy
- Electroshock Therapy in or out of the hospital including the administration of anesthesia by a physician other than the doctor who provides the treatment.

Doctor's office visits billed separately in connection with Medical Care Benefits are considered under the "Other Covered Charges" portion of the Plan.

For the following services, Medical Care Benefits are payable at *90%* of the reasonable and customary charge:

- Administration of Anesthesia by a phyisician other than your surgeon or his or her assistant. Benefits are payable only for surgical procedures covered by the Plan.
- In-Hospital Doctors' Visits. Benefits are payable for one visit each day by a doctor while you're in the hospital. No benefits are paid in surgical cases under this part of the Plan since the cost for post-operative services is included in your surgeon's fees.
- Well-Baby Care. Benefits are paid for one pediatric examination of a new born child during the mother's confinement.
- In-Hospital Consultation. Benefits are paid for one consultation between your physician and another specialist while you're in the hospital. If your condition requires the attention of a number of specialists in different specialties, benefits will be paid for the first consultation with each.

Remember that benefits for "Other Covered Charges" can pay most of the remaining reasonable and customary charges for those services which are not paid at 100%.

ALCOHOLISM REHABILITATION BENEFITS

Your Medical Expense Plan also pays benefits for care received in an institution which provides an "alcoholism treatment program" approved by the Joint Commission on Accreditation of Hospitals. These benefits are *limited* to you and your Class I dependents. Here's what is paid.

For each separate stay, the Plan will pay the *full* cost of semi-private accommodations for up to *30* days. Only *two* stays are covered for any one person during his or her lifetime. The second stay must start at least *180* days after the first one ended to be considered separate from the first.

Any amounts not paid for this type of care are *not* reimbursable under "Other Covered Charges" described next.

BENEFITS FOR "OTHER COVERED CHARGES"

As you've read, the Medical Expense Plan pays most of the costs for several different and important medical services. However, there are some charges that are not paid in full by the other parts of the Plan. And there are some additional covered expenses such as prescription drugs, private duty nursing services, etc., which the other parts of the Plan don't cover at all.

That's where benefits for "Other Covered Charges" step in to help.

Benefits for "Other Covered Charges" are payable for expenses incurred during a calendar year. An individual deductible of 1% of your annual basic pay or pension benefit (maximum of $150, minimum of $25) will be applied to these charges.

After you meet the deductible, this part of the Plan pays:

- *80%* of any remaining "Other Covered Charges" —except for non-hospital psychiatric care—until all covered expenses payable under "Other Covered Charges" total $5,000—then the Plan pays
- *100%* of any "Other Covered Charges" you incur during the rest of that calendar year.

The *100%* reimbursement rate applies after "Other Covered Charges" exceed $5,000. This puts a cap on how much you have to pay for covered expenses in any year no matter how serious the condition or how costly the care.

For non-hospital psychiatric care the benefit is always 50% unless you (the employee) are the patient and are

out of work due to mental disability. If you are, then the benefit for this type of care is 80%—subject to the higher 100% reimbursement rate after the total of "Other Covered Charges" in any calendar year reaches $5,000.

Here's what's covered by this part of your Plan:

- charges for semi-private hospital room, board and other services beyond 120 days or beyond 30 days for semi-private hospital care for the treatment of mental and nervous conditions, alcoholism treatment or drug addiction.
- reasonable and customary charges of a surgeon or a physician above those paid by Surgical and Medical Care Benefits of the Plan.
- physiotherapy if prescribed by a physician and performed by a qualified physiotherapist
- prescription drugs
- blood (if not replaced)
- artificial limbs and eyes (but not their replacements)
- medical equipment rentals (e.g., wheelchairs)
- local ambulance service to the nearest hospital where treatment is first given.
- expenses incurred for the professional services of a registered graduate nurse (RN) or a licensed practical nurse (LPN)—other than a nurse who resides in the covered individual's home, or is a member of such individual's immediate family—may be covered.

  Payment will be made for *only that portion* of the nurse's services performed that require the special knowledge and skill of a trained professional nurse, and then only upon receipt of a physician's

written documentation of such need and a listing of the special care services to be provided. *Nursing care is not covered for routine patient care that is provided by a registered nurse or which is provided by a nonprofessional individual on a maintenance of care basis.*

The initial claim for nurse's services filed in each medical expense period must be accompanied by the prescribing physician's written documenation, the nurse's bills and the nurse's notes for each tour of duty represented by the bill. *Subsequent claims* for the same medical expense period should be accompanied by a copy of the nurse's bill and the nurse's notes for each tour of duty represented by the bill.

Upon request, you must furnish the carrier additional information as required to substantiate the continued need for nursing services.

Filing of these type claims on a weekly basis will reduce the likelihood of misunderstanding in the determination of your benefit entitlements.

Maximum Benefits

While you are an *active* employee—and while your dependents are then under age 65—there is *no* limit to the amount of benefits payable under the "Other Covered Charges" portion of the Plan.

As a *retired* employee, the maximum benefit is *$50,000.* This maximum applies during your entire lifetime and for each of your dependents. The $50,000 maximum also applies to your dependents over age 65 whether you are active or retired. However, the first $3,500 of benefits in any year does not count against the maximum. This means that regardless of whether you met the maximum, a benefit of at least $3,500 is available for covered medical expenses incurred each calendar year.

EXAMPLES

The best way to see how the various parts of your Plan work together is to look at some examples.

Example 1

An employee undergoes a minor operation. Since the surgery only requires local anesthesia, the surgeon suggests the operation be performed in an ambulatory surgical facility. The employee can check into the facility in the morning and be on his way home before noon. The employee's basic annual earnings are $13,000, so his deductible is $130—i.e., 1% of $13,000. Here are his bills and the help he got from the Plan. All charges were determined by the insurance carrier as falling within the reasonable and customary range.

Expenses	Bills	Hospital Care Benefits Paid	Surgical Care Benefits Paid	Medical Care Benefits Paid	"Other Covered Charges" Considered
Office visit	$ 50	$ —	$ —	$—	$50
Second surgical opinion	40	—	—	40	—
Diagnostic X-ray and laboratory charges	30	—	—	30	—
Charge for ambulatory surgical facility	150	150	—	—	—
Surgeon's fee	300	—	285	—	15
Prescription drugs	25	—	—	—	25
Totals	$595	$150	$285	$70	$90*

The Plan paid all but $90 of the cost of the employee's surgery—or *85%* of the total costs.

* Since "Other Covered Charges" were less than the employee's deductible, no benefits were paid by this part of the Plan. However, the $90 which the employee paid will be applied to his deductible leaving only $40 remaining to be satisfied during the rest of that year.

Example 2

An employee is hospitalized for serious surgery. Her hospital stay lasts for 13 days and she requires the services of private duty nurses. During the course of her treatment, she briefly develops some breathing difficulties and her surgeon consults with a lung specialist. After being discharged from the hospital, she has follow-up outpatient lab tests and is required to take medications prescribed by her doctor. Her basic annual earnings are $16,000 so her deductible is $150—the maximum individual deductible anyone has to meet under the Plan.

Here are her bills and the benefits paid by various parts of the Medical Expense Plan. All charges were determined by the insurance carrier as falling within the reasonable and customary range.

Expenses	Bills	Hospital Care Benefits Paid	Surgical Care Benefits Paid	Medical Care Benefits Paid	"Other Covered Charges" Considered
Semi-private hospital room, board and other services 13 days @ $200 a day	$2,600	$2,600	—	—	—
Surgeon's fees	1,800	—	$1,710	—	$90
Administration of anesthesia	600	—	—	540	60
Consultation	150	—	—	135	15
Private duty nurses 7 shifts at $80 a shift	560	—	—	—	560
Prescription drugs	80	—	—	—	80
Follow-up outpatient lab tests	200	200	—	—	
Totals	$5,990	$2,800	$1,710	$675	$805
				deductible	—150
					$655
					x 80%
					$524 paid

The Plan paid $5,709—or *95%* of the entire cost.

CLAIMING BENEFITS

All the benefits provided by this Plan can be claimed using the Medical Expense Plan claim form. You can obtain a claim form from your Supervisor or Area Benefit Office.

Following the instructions for completing the form and send it along with all itemized bills to Aetna Life & Casualty, Southern Bell Division, P.O. Box 189, Macon, Georgia 31298. Medicare eligible individuals should also send the Explanation of Medicare Benefits (EOMB Form).

Claims should be as complete as possible and must show:

- employee's full name and Social Security number
- full name and Social Security number of patient
- date of service and where provided
- diagnosis
- type of service
- amount charged
- registration or license number of registered nurse or licensed practical nurse.

In addition, bills for prescription drugs should show the prescription number, the purchase date and the name of the prescribing physician.

It is recommended, whenever possible, that all claims be submitted to the insurance carrier within 90 days after the medical expenses are incurred or after the end of the calendar year.

EXCLUSIONS

Although your Medical Expense Plan covers a broad range of services and supplies, there are some items—

as in all plans of this type—that are *not* covered. These include:

- continued hospital confinement which commenced prior to the effective date of the Plan
- charges for any services received before you and your dependents' coverage under this Plan began
- occupational illness or injury which is covered by Workers' Compensation
- routine health checkups
- diagnostic tests (except Pap Smears) which do not reveal either an illness or injury unless you submit proof satisfactory of the insurance carrier that you had specific symptoms of a condition requiring medical attention
- hospital private rooms and board charges in excess of the semi-private room rate or—if in an all-private room hospital—in excess of 90% of the most prevalent private room rate
- charges paid or payable under the laws of any country—or for which you have no legal obligation to pay.
- charges in excess of those considered reasonable and customary by the insurance carrier
- hospitalization for dental care unless required because of an accident or to safeguard your health
- charges for any dental work or treatment except to the extent specifically provided under the terms of this Plan
- charges for in-hospital personal services—e.g., radio and TV rentals, guest meals, barber, etc.
- charges for eyeglasses or hearing aids and related examinations or prescriptions for them, except initially because of surgery or injury

- charges for care in a nursing home, convalescent home, custodial care or rest cures
- cosmetic surgery or treatment unless required because of an accident which occurred after your coverage under this Plan began or to correct a birth defect
- illness or injury caused by an act of war—declared or undeclared.
- charges for services unique to chiropractics, except where mandated by state law.

The Plan is intended to reimburse you for necessary medical expenses incurred for the care and treatment of injury and disease. Therefore, any charges for care, treatment, services or supplies that are not determined to be medically necessary for the treatment of an injury or a disease or which are provided solely for your convenience *will not be paid by the Plan.*

IF YOU BECOME DISABLED

If you become disabled before retirement and receive benefits under one of the Company's Long Term Disability Plans, your coverage and your dependents' coverage will continue subject to the same $50,000 maximum which applies to retired employees and their dependents —see page 15. However, when you die, *no* coverage will remain for your dependents.

TERMINATION OF COVERAGE

One of the many valuable features of the Plan is that coverage doesn't terminate when you retire with either a Service or a Disability Pension. Your deductible shifts to a percentage of your pension rather than your pay and, if applicable, your coverage adjusts to take into account payments from Medicare. Otherwise, all the basic features of the Plan continue. The Plan—and the protection it provides—can continue for life.

There are, however, some circumstances in which coverage can terminate. And you should know about them.

Coverage, of course, *stops* if you leave the Company before retirement. It terminates on the last day of the month in which your employment ends. It also terminates on the last day of the month in which, for any reason, you request that your coverage be cancelled. If your coverage stops for either of these reasons, your dependents' coverage stops too.

Coverage for the surviving spouse and dependents of a deceased active or retired employee will continue until the last day of the sixth full month following your death. Your *spouse* may then continue this same coverage by writing to the insurance carrier and making arrangements to pay for it. The cost to your spouse will be based on the current group rate.

Your dependents' coverage will stop on the last day of the month in which they no longer qualify as dependents either due to age, a change in full-time student status, marital status, residency or income.

If coverage terminates, no further benefits will be paid by the Plan unless the individual is in the hospital. If so, Hospital Care Benefits only will continue to be paid for as many days as remain in that particular stay. Then all benefits stop.

Special provisions apply to *layoff* and an *approved leave of absence.* If you leave work because of a layoff, you can continue your coverage and that of your dependents for *90 days* by paying the full premium charged. In case of an *approved leave of absence*, you can continue coverage for yourself and your dependents for as long as the leave lasts, also by paying the full cost charged by the insurance carrier. For purposes of this provision, a leave to enter military service is not considered an "approved leave." If you go into the military, your coverage and that of your dependents will stop under this Plan.

CONVERSION RIGHTS

If coverage terminates either for you or one of your dependents, it can be converted to a non-group policy issued by the Aetna Life Insurance Company. This coverage will provide hospital, surgical and medical benefits similar (but not necessarily the same) to those provided by your Company Plan. No medical examination will be required, if you file a written request for this coverage directly with Aetna Life Insurance Company within 31 days after your Company coverage ends.

WHEN YOU RETIRE

If you retire from the Company on a Service or Disability Pension, your coverage will continue during your retirement. It will continue for your dependents as well.

When you retire coverage will be the same in all respects as it is now with the following two exceptions related to "Other Covered Charges" on the first of the year following your retirement:

- deductible—it will change to 1% of your annual pension benefit but it will still be no more than $150 nor less than $25
- maximum lifetime benefits—becomes $50,000, but the first $3,500 of benefit payments each year will not count against the maximum.

The Company will continue to pay the full cost of your Plan benefits.

WHEN YOU ARE ELIGIBLE FOR MEDICARE

Once you or any of your dependents become eligible for Medicare—see page 4—the Plan will *not* reimburse any benefits payable under the law. The Plan will subtract any benefits available under Medicare from the Plan benefits you can receive. In *combination* with Medicare, however, the Plan will continue to provide the same level

of coverage you have under the Plan alone. So, it's important to sign up for Medicare when first eligible to assure complete coverage. Contact your local Social Security office for details.

COORDINATION OF BENEFITS

Your Medical Expense Plan contains a Coordination of Benefits (COB) provision which is designed to ensure your full entitlement to benefits and prevent duplication of payment. It applies when an employee or dependent is covered by more than one group, pre-payment or employer-sponsored medical plan.

This includes any benefits paid under any government program (except Medicare). The COB provision does *not* apply to any personal policies of insurance you may own.

Under the COB provision, the insurance carrier determines which plan has primary responsibility and which plan has secondary responsibility. The primary plan always pays first. Briefly, COB works like this:

- When the other plan does not have a Coordination of Benefits provision, it is considered primary.
- When both plans have Coordination of Benefits provisions. . .

  —The plan covering the person as an employee is primary and will pay benefits up to the limits of that plan; the plan covering the patient as a dependent is secondary and pays any remaining eligible costs.

  —The father's group insurance is the primary plan and will pay the children's benefits first; the mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.

  —If the parents of a dependent child are divorced or legally separated, the insurance carrier will

determine if there is a court decree which establishes financial responsibility for medical and dental care. If there is such a decree, the plan covering the parent who has that responsibility will be the primary plan.

—If there is no decree, the plan which covers the child as a dependent of the parent with custody will be the primary plan. The other parent's plan is secondary.

—If there is no decree and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan is secondary.

—If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan.

Benefit claims should always be filed first with the primary plan. Under the COB provision, you and your dependents can receive up to *100%* of covered medical charges from all plans combined—but no more than that.

OTHER IMPORTANT INFORMATION

Alternate Choice Plan

Each year you will be given an opportunity to retain your Medical Expense Plan coverage or to replace it with any approved Health Maintenance Organization (HMO), if available in your locality. However, to make such a choice, an agreement must have been established between the Company and the HMO in the area in which you live.

If such an option is available to you—and you elect to make use of it for yourself and your dependents—the Company will contribute the same amount toward the cost of this alternate medical coverage as it does toward the cost of your Medical Expense Plan. Any additional costs for such a plan—based on the enrollment costs estab-

lished by that Health Maintenance Organization—will be paid by you through payroll allotments.

Plan Administrator

Southern Bell Telephone and Telegraph Company, 42P75, Southern Bell Center, Atlanta, Georgia 30375 administers the Plan. The telephone number is (404) 529-8731.

Plan Administration

The Medical Expense Plan is underwritten by Aetna Life Insurance Company, 151 Farmington Ave., Hartford, Ct. 06156. The master contract between the Company and the insurance carrier governs the operation of the Plan at all times.

Plan Contributions

The Company's contributions for coverage—and employees' contributions when required (see page 6)—are included in the total premium paid by the Company to Aetna Life Insurance Company.

Payment of Benefits

Aetna Life & Casualty pays the benefits provided by this Plan.

Denial of Claim and Appeal Procedures

If a claim for Plan benefits is denied, either in whole or in part, you or your dependents will receive written notification from Aetna Life & Casualty. This written notification will include:

1. The specific reason or reasons for the denial.
2. Specific reference to pertinent Plan provisions on which the denial is based.
3. A description of any additional material or information necessary for the claimant to perfect

the claim and an explanation of why such material or information is necessary.

4. Appropriate information as to the steps to be taken if you, your dependent or a duly authorized person representing you or your dependent wish to submit the claim for review.

However, if you do not hear from the insurance carrier within 90 days after it receives your claim, submitted according to the procedures on page 18 of this booklet, your claim is considered denied.

If a claim for benefits is denied or you or your dependent feel you have been treated unfairly with respect to the Plan, you, your dependent or other duly authorized person may appeal this denial or other action in writing within 60 days after your receipt of notification of the insurance carrier's decision or, if no such notification is received, within 60 das after the 90 day period discussed above has lapsed. Written request for review of any denied claim or other disputed matter should be sent directly to the insurance carrier at the address listed on page 18 of this booklet. The person sending the request has the right to:

1. Review pertinent Plan documents which may be obtained by following the procedures described in this booklet under "Plan Documents," see page 28, and

2. Send to the insurance carrier a written statement of the issues and any other documents in support of the claim for benefits or other matter under review.

The insurance carrier will provide a written response to the appeal within 60 days after it is received. However, the insurance carrier has the exclusive right to interpret the provisions of the Plan, so its decision is conclusive and binding. In any case, as a participant or

a dependent of a participant in the Plan, you may have further rights under the Employee Retirement Income Security Act of 1974—see "Your Rights as a Plan Participant," page 28.

Legal Service

Process in legal actions with respect to the provisions of the insurance contract should be directed to Aetna Life Insurance Company, 151 Farmington Ave., Hartford, Ct. 06156. All other process concerning the Plan should be directed to Southern Bell Telephone and Telegraph Company, 42P75, Southern Bell Center, Atlanta, Georgia 30375.

Plan Records

The Medical Expense Plan and all of its records are kept on a calendar year basis.

Plan Identification Numbers

The Plan is identified by the following numbers under Internal Revenue Service rules:

#58-0436120 —Employer Identification Number assigned by the IRS

#522 —Plan Number—assigned by the Company.

Plan Continuance

The Company fully intends to continue the Medical Expense Plan indefinitely but reserves the right to end or amend it at any time, subject to any applicable collective bargaining agreements.

The benefits described in this booklet are also outlined in the current agreements between the Company and the Communication Workers of America representing Southern Bell employees in collective bargaining units. Copies

of these agreements are distributed or made available to employees covered by them.

Plan Documents

The information contained in this booklet describes only the highlights of the Medical Expense Plan. It is a Summary Plan Description as defined by the Employee Retirement Income Security Act of 1974 (ERISA). It does not attempt to cover all details. These are contained in the master contract between Aetna Life Insurance Company and the Company which legally governs the operation of the Plan. The master contract, as well as the annual report of Plan operations and Plan description filed with the federal government are available for review by Plan participants or their dependents in the Corporate Secretary's Office or at the Area Benefit Office during normal working hours. Upon written request addressed to Corporate Secretary, Southern Bell Telephone and Telegraph Company, 42P75 Southern Bell Center, Atlanta, Georgia 30375, any or all of these documents will be furnished to a Plan participant or dependent within 30 days at a reasonable charge.

Your Rights as a Plan Participant

The benefits provided by the Medical Expense Plan are covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was signed into law for the purpose of protecting your rights under employee benefit plans. The law does not require a company to provide benefits but ERISA does set standards for any benefits a company wishes to offer—and it requires that you be given an opportunity to learn what these benefits are and your rights to them under the law.

It is your right to know as much as possible about your benefits. This Summary Plan Description is one way to help keep you informed.

As a participant in the Medical Expense Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as selected work sites, all Plan documents, including the insurance contract with the insurance carrier, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for such copies;

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants. No one, including your employer, your union or any other person, may fire you or otherwise discriminiate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a benefit under this Plan is denied, in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to have the Plan review and reconsider your claim. Your rights of claims and appeal of denied claims are set forth in the section entitled "Denial of Claim and Appeal Procedures."

Under ERISA, there are steps you can take to enforce the rights outlined above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay out up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who will pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Medical Expense Plan you should contact your Benefit Office or the Plan Administrator. If you have any questions about this statement of your rights, or your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

State Mandated Requirements:

In addition to the benefits provided by the Medical Expense Plan, the State of Georgia, where the group contract is issued, requires that the following benefits be included in the Medical Expense Plan contract.

—Doctors of Chiropractic and Optometry will also be recognized as long as they have a license under the

applicable state licensing law and they are acting within the scope of their license when rendering any service for which a benefit is payable under the group contract. Certain limitatons in the Plan Exclusion section of your Booklet apply to the use of Chiropractors.

—The Medical Expense Plan will coordinate with other benefits except under (a) any blanket school accident policy, (b) any individually underwritten and issued contract which provides exclusively for accidents and health insurance and where 100% of the premiums have been paid by the insured regardless of the method of premium payment, (c) any no-fault automobile reparation insurance.